STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006597	A. BUILDING: _____ B. WING _____	C 07/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE HALL NURSING & REHAB CENTER	620 WEST BRIDGEPORT WHITE HALL, IL 62092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation #1643518/IL86500	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

procedures:

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on observation, interview and record review, the facility failed to document timely investigations after a resident fall and failed to implement fall interventions in a timely manner to prevent future falls for one of three residents (R2) reviewed for falls in the sample of seven. These failures resulted in R2 sustaining a right wrist fracture.

Findings include:

An Interdisciplinary Fall Reduction/Injury Prevention Protocol dated 7/2012, documents each fall is to be investigated as soon as possible post fall, by all staff members working on that unit...the Director of Nursing Services (DNS) and the Interdisciplinary team (IDT) to discuss each fall in the daily meeting...notify the team of the fall

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S9999	Continued From page 2	S9999		

and new intervention implemented in the morning meeting. A summary of each fall should be written in the IDT notes by the DNS/designee during the safety meeting, which is to include a description of the fall, causative factors and interventions implemented.

R2's Care Plan dated 2/5/16, documents R2 is at risk for falls due to a history of falls and a diagnosis of Dementia and requires assist of one staff member and a gait belt for transfers. R2's Minimum Data Set Assessment dated 6/12/16, documents R2 has moderately impaired cognitive skills and requires extensive assistance of one staff member for transfers and ambulation.

A Resident Incident Report dated 4/7/16 at 12:45 p.m., documents R2 was found sitting on the floor next to wheelchair. An IDT Note dated 4/13/16 (6 days after R2's fall), documents interventions which include, "non slip strips in front of bed."

A Resident Incident Report dated 6/12/16 at 11:50 p.m., documents R2 was found on the floor at foot of bed. R2 complained of right hand pain. An x-ray report dated 6/13/16, documents R2 sustained a right distal radius fracture.

At approximately 10:30 AM on 6/30/16, no non slip strips were present by R2's bed.

On 6/30/16 at 12:45 p.m., E10 (Certified Nurse Aide) verified R2's room did not have any non slip strips on any side of R2's bed.

On 7/5/16 at 11:36 a.m., E3 (Director of Nursing Services) verified R2's room did not have non slip strips in place on 6/30/16.

A Resident Incident Report dated 3/23/16 at 7:30

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S9999	Continued From page 3	S9999		

p.m., documents R2 was found on the floor next to the bed. A Post-Incident Actions report dated 3/23/16, documents Immediate Post-Incident Action was "Gripper socks placed on feet. Therapy to screen." A weekly fall safety meeting dated 4/8/16 (16 days after R2's fall), documents "resident was trying to take pants off, went to sit on the bed, missed the bed and fell."

A Resident Incident Report dated 4/22/16 at 6:30 a.m., documents R2 was found on the floor between the bed and doorway. R2 received a 9 centimeter skin tear to the left elbow. A Post Incident Actions form dated 4/22/16, documents therapy to screen R2. A Therapy Screening form dated 4/22/16, documents R2 fell out of bed and a therapy evaluation is recommended. A Physical Therapy Plan of Care dated 5/16/16 (24 days after therapy evaluation was recommended), documents R2 was started on Physical Therapy Services.

On 7/5/16 at 12:10 p.m., E3 (DNS) stated R2's physician was on vacation and the facility was waiting on the order to evaluate R2 for therapy. E3 stated R2's physician does have a Physician's Assistant in the office and E3 does not know why an order was not received or why the facility did not pursue an order.

A Physical Therapy Plan of Care dated 5/16/16, documents R2 requires moderate assistance with transfers and moderate assistance in gait with wheeled walker due to an exacerbation of Dementia. A Resident Incident Report dated 5/18/16 at 6:15 p.m., documents R2 got out of bed and walked to doorway and R2 stated she slipped. An IDT note dated 6/1/16 (fourteen days after R2's fall), documents R2 was changed to stand by assist.

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S9999	Continued From page 4	S9999		

On 7/5/16 at 11:36 a.m., E3 (DNS) verified R2's IDT note dated 6/1/16 documents R2 was changed to stand by assist even though R2's therapy notes document R2 required moderate assist with transfers and ambulation.

E3 also verified E3 has a hard time getting safety meetings done in a timely manner and changes need to be made to the fall investigation process.

(B)